# Quarterly Progress Report No.4
# Quarter Four, FY 2011
# July—September 2011

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**MATERNAL AND CHILD HEALTH INTEGRATED PROGRAM**

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## MCHIP OVERVIEW

### Background

The Maternal and Child Health Integrated Program (MCHIP) in Indonesia is a USAID-funded, three year program that will run from January 2010 to December 2012, with a budget level of USD 9.8 million. This program is being implemented by Jhpiego, in collaboration with Save the Children (SC) and John Snow Inc. (JSI). In support of the MOH Road Map to the 2015 MDGs, MCHIP/Indonesia is being implemented in three districts that are classified as "Health Problem Areas": Serang District in Banten Province; Kutai Timur District in East Kalimantan Province; and Bireuen District in Aceh province. All districts have areas that are considered "remote". JSI is leading the activities in Serang; Jhpiego in Kutai Timur, and Save the Children in Bireuen.

In April 2011, the program workplan was revised to accommodate scaling up of life-saving interventions throughout the 3 target provinces. This quarterly report reflects the addition of a sub-objective aimed at taking interventions to scale at the provincial level.

The overall objective of the program is to catalyze implementation of existing policies that promote key **evidence based life saving interventions at scale** in remote areas. To achieve the program goals, MCHIP inputs are contributing to four sub-objectives:

1. Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces.
2. Improve maternal and newborn care in the community
3. Improve quality of clinical services at all levels of care
4. Improve management of district health system

Results:
- District teams in three remote areas scaling up high impact interventions district-wide
- Provincial teams in three remote areas implementing plans to scale up high impact interventions in other districts, using technical assistance from core districts.

| **Sub Objective 2: Improve Maternal and Newborn Care Practices at the Community Level** | **Sub Objective 3: Improve Quality of Clinical Services at all Levels of Care** | **Sub Objective 4: Improve Management of the District Health System** |
|---|---|---|
| Results:<br>• Expanded use of life saving approaches (postnatal care, KMC, CCM) by village midwives and kaders<br>• Increased knowledge, skills and practices of healthy maternal and neonatal behaviors in the home<br>• Communities mobilized for action and advocacy | Results:<br>• Improved competencies of health care providers for pregnancy, childbirth and postnatal care, including AMTSL, PE/E, newborn resuscitation, and KMC<br>• Improved systems for assuring quality of care, including the use of performance standards and maternal-perinatal audit | Results:<br>• Increased use of evidence-based planning at all levels of the health system<br>• Improved use of LAMAT and MPA to monitor district programs and achievements<br>• Institutionalized support and resources for maternal, neonatal and child health |

# QUARTER 3 RESULTS

**Major accomplishments**

- Preparation of mini university has been carried out in 3 districts, socialization to DHO has been conducted to give understanding how the mini university will be disseminating the information about detailed program activities and budget.
- Mother's support groups established in 3 target districts, in Bireuen mother's group has been conducted 3 times. While in other districts they are starting with socialization, facilitator training and conduct the first cycle.
- Midwives and TBAs partnership carried out in 3 districts, a monitoring conducted in Serang; MoU has been signed in Kutai Timur; partnership initiated in Bireuen.
- Modul CCM/KMC has been finalized and distributed in Kutai Timur and Bireuen.
- Initiation and discussion on integrated PNC carried along in this quarter, some districts have good respon to implement the integrated PNC.
- SBMR assessment has been conducted at hospital, Puskesmas and midwives level for the third cycles with increasing result.
- To address the better health information system, the MCH strengthening in 3 districts conducted through the LAMAT-MCH orientation and training.
- MCHIP continuing assists the district to advocate the activity proposal to ensure the allocation in 2012 budget.
- Progress toward MCHIP indicators for all sub objectives summarized in Annex 1 and 2.

## Narrative description

## Sub-objective 1: Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces.

MCHIP has been working with the three districts to ensure that they have completed their District Road Maps and have submitted them to the Provincial Bappeda. The District road map is a tool for the districts to document the district level MNH targets to meet the MDGs for Maternal and newborn health.

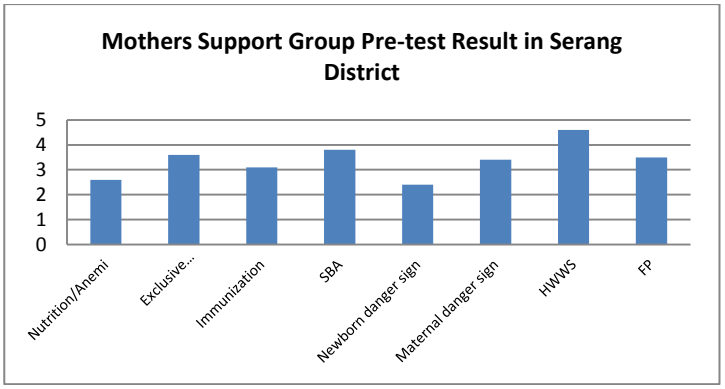
In order to catalyze province-wide scale up, a MCHIP Mini-University will be conducted to showcase the MCHIP intervention package, program implementation guidelines, lessons learnt to date, and cost guidelines for each intervention. Each province will organize a Mini-University for the district and provincial officials. The goal of the Mini-university is stimulate non-MCHIP districts to initiate or revitalize national program and policies, based on the experience of MCHIP target districts. Upon request from the non- MCHIP districts, the MCHIP district will then provide technical assistance to implement these interventions. The tentative dates for the Mini-university are March/ April 2011 in all three provinces. The MCHIP team has met with the Provincial and District officials to socialize the concept of Mini University in their provinces. In addition to logistics, the MCHIP team is also preparing program learning documentation for the Mini-University.

***Mini-university Preparation***. MCHIP staff conducted meeting with the PHO and DHO to discuss plans for Mini-University events. In Bireuen, meeting conducted in July 5-7 with 23 districts in NAD province, also attended by MOH representative. Some DHO interested and gives positive respond to request technical assistance from MCHIP target districts. Similar meeting conducted in Serang with Banten PHO with follow up to establish a Mini University committee to assist the implementation of mini university in Banten province. Also in Kutai Timur socialization of mini university conducted in a meeting with PHO and DHO in July.

**Sub-objective 2: Improve Maternal and Newborn Care Practices in the Community**

***Mother's classes (Kelas Ibu).*** *Kelas Ibu* are Mother's classes at the village level where pregnant women and mothers are given key messages in maternal and newborn areas including nutrition/ anemia, exclusive breastfeeding, immunization, skilled birth attendant, newborn and maternal danger signs, hand washing, and family planning. The implementation of Kelas Ibu carried out in 3 districts in 153 villages (62 villages in Bireuen, 26 villages in Kutai Timur and 65 villages in Serang). Facilitator training has been conducted in Serang in June and Kutai Timur in August. There are 197 facilitator has been trained in Serang and 17 facilitator trained in Kutai Timur. In Bireuen, routine meeting with Puskesmas conducted to monitor Kelas Ibu implementation. It was agreed that sub districts will allocated budget for Kelas Ibu implementation. In Bireuen, Kelas Ibu attended by around 300 pregnant women and mother with babies in all target villages in each ditrict and has it third cycle. Topics covered to date include breastfeeding, birth planning, and danger signs.

In the first cycle of Kelas Ibu implementation, a pre-test was given to the participants to measure their knowledge on key practices. There are 5 questions for each key practices which includes nutrition, exclusive breastfeeding, immunization, skilled birth attendant, danger sign for mother and newborn, handwashing with soap and family planning. Below graphs shows result pre-test from Serang. It is shown that handwashing is the highest score after skilled birth attendant and exclusive breastfeeding. The total score for each key practice is 5.



***Midwife-TBA partnerships.*** To increase skilled attendance and facility-based births, one of the approaches the government is pursuing is to promote partnerships between midwives and TBAs by clarifying roles, agreeing on mutual financial compensation, and providing recognition of strong partnerships. MCHIP team after visiting the Midwife-TBA partnership model site in Takalar in South Sulawesi adopted this approach in the three MCHIP districts. MCHIP's role in the district is to build capacity of the puskesmas to facilitate the relationship between TBAs and midwives; to clarify and to reach a consensus on the roles of TBAs and midwives in relation to childbirth. As an output a Memorandum of understanding between the Midwives and the TBAs stating the role of TBAs as providing care and comfort to the women during childbirth and the midwife managing the birth was developed..
Continuing from last quarter, good progress was made in revitalizing or establishing midwife-TBA partnerships in each district. In Serang District, following MoU signatory in last quarter, a monitoring of midwives –TBAs has been conducted in Serang. Sone factors has been identified as the success factor of partnership: commitment between midwives and TBAs; support from stakeholders, presecption from the public; and completeness of administration. In Kutai Timur, Socialization and MoU signature for two districts conducted in August.

***CCM and community KMC***. Community Case Management (CCM) is a strategy to deliver life-saving curative interventions for common serious childhood infections (newborn sepsis, pneumonia, diarrhea and malaria) for children under 5 in communities with limited access to facility-based care. Kangaroo Mother Care (KMC) in Indonesia is primarily a facility based intervention to manage Low Birth Weight. MCHIP in Indonesia is piloting CCM for newborn sepsis, pneumonia, and diarrhea and expanding the KMC to the community level in the MCHIP target districts of Bireun and Kutai Timur. Indonesia currently does not have a national policy on CCM; finding from the CCM pilot will inform the national level policy.

In Quarter 4 in Bireuen, series of training conducted to continue the implementation, 10 person trained in CCM/CKMC supervisor training and 11 villages midwives trained in CCM/CKMC Newborn Training in 6 target Puskesmas.Monitoring of CCM/CKMC implementation and reporting system has been carried out for 63 villages midwives, it is found 8 cases in Peudada subdistrict. A competency test has been conducted to assess the skills and knowledge of 30 health workers and cadres who was trained in 6 target subdistrict.

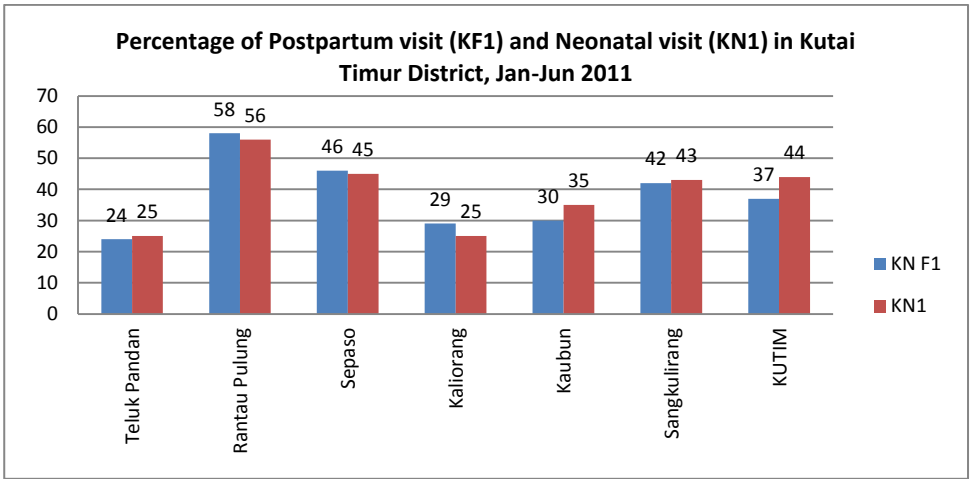
***Handwashing for newborn survival.*** MCHIP, in collaboration with Hygiene Center of the London School of Tropical Medicine (LSHTM) and Unilever, conducted a study in Serang district to identify opportunities for handwashing for mothers and newborns. The study aimed to answer questions around the context and practices of handwashing among those who come into contact with newborn. The study found that handwashing with soap (HWWS) was rare before meals and occasional after meals. Water and soap availability was not a barrier to handwashing. HWWS was more frequent in households in urban areas, and among better educated and more affluent women. Women do not associate hand-washing with illness. Hand-washing with soap (HWWS) was observed to occur on at least one occasion in half of the households under study, and was seen to occur after sweeping, doing laundry and returning home (in urban areas). HWWS was rare before meals and occasional after meals. HWWS after changing the baby's napkin was observed in some households. Water and soap availability was not a barrier to hand-washing. HWWS was most frequent in households in urban areas, and

among better educated and more affluent women  A foundation of practice for HWWS exists in Serang  on which a hand-washing promotional campaign can be built. Another important finding is that women trust midwives more than TBAs, although both types of birth attendants have important roles and influence over new mothers.Midwives and TBAs, given their influence over women and frequent number of contacts with women post-delivery could be the conduit of HWWS amongst mothers

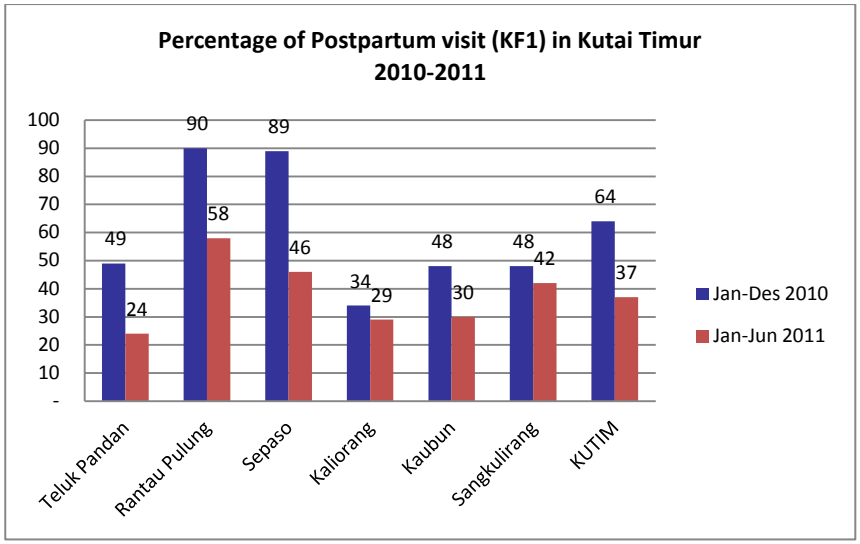
Based upon these findings, IEC materials to promote handwashing for mothers and newborns are currently being developed with Unilever support. These findings from Indonesia, as well as a study in Bangladesh, will contribute to the global understanding and best practices for the handwashing and newborns. At the national level, MCHIP will continue to advocate for inclusion of handwashing for mothers with newborns in national programs. MCHIP, in collaboration with the Global Alliance for Handwashing, is also planning handwashing with soap campaigns in the three districts for the Global Handwashing Day on October 15th. In Serang, the campaign will be launched by the Bupati. Handwashing day was also celebrated with high visibility events in all three districts in 2010.

**Sub-objective 3: Improve quality of clinical services at all levels of care**

***Integrated Postnatalcare,*** In 3 districts, socialization of IPNC start in district and subdistrict level. District prepare the implementation by enriched the existing form to ensure that the neonatal visit and postpartum visit is integrated. It is emphasize that integrated postnatalcare is part of midwives' role in recording and reporting, where in most sub-districts is the weaknesses.
In Kutai Timur, IPNC was discussed and socialized with Local Secretary (Sekda), multisectoral and health centers to gain commitment from local government.
Looking at the current number of neonatal and postpartum visit that recorded at Puskesmas level, it shows that integrated PNC has started to be known in 3 districts. Below graphs shows the percentage of postpartum and neonatal visit in Kutai Timur district.




Comparing with 2010 data, below graph shows the 6 months achievements in 2011 (Jan-Jun 2011) reached more than a half of one year achievements in 2010 (Jan-Dec 2010). It can be estimated that by the end of 2011, achievement will be more than 2010.

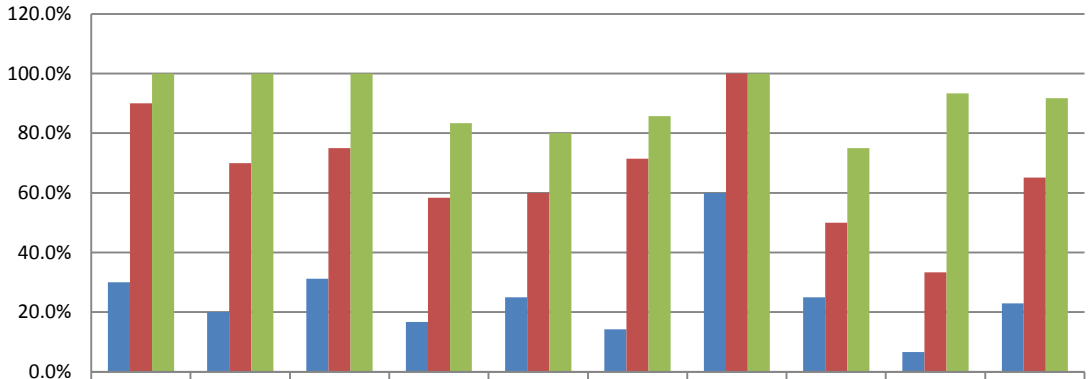



***Kangoroo Mother Care (KMC),*** MCHIP is expanding facility based KMC in three MCHIP target hospitals in the three districts. *Perinasia* (Indonesian Perinatologist Association) who had been leading the effort of establishing facility based KMC under the HSP, is providing technical assistance to MCHIP for KMC expansion. Perinesia continue to do a monitoring evaluation of implementation of KMC in three hospitals in 3 districts. A series of reccomendations generated from this monitoring and evaluation to strengthen the implementation of KMC in hospitals. See Annex 4 for summary of reccomendations.

***Active Management Third Stage Labor (AMTSL),*** BEST has highlighted AMTSL as an immediate, high- impact intervention to take to scale for maternal health. MCHIP is providing inputs to ensure that all midwives in the MCHIP subdistricts are competent in AMTSL. Abaseline assessment of AMTSL competency was conducted in all three MCHIP target subdistricts to identify the percentage of village midwives competent in AMTSL. The survey participants included 329 midwives from MCHIP and non-MCHIP districts - midwives who had received BEMoNC training that includes AMTSL as well as those who had not. The result shows there are 40% village midwives who could correctly perform AMTSL in Bireuen, 5% in Kutai Timur, and 52% in Serang. Results by three AMTSL steps show that administration of oxytocin injection after the birth, and massage of the fundus uterus after the expulsion of the placenta is performed correctly by majority of midwives. Majority of midwives did not perform control cord traction immediately after contraction, instead waiting for the placenta to be released, leading to blood loss. As a follow on, MCHIP is conducting on the job training of AMTSL for these midwives with an emphasis on control cord traction management followed by another assessment in the next six months. Understanding that while midwives are trained, other factors such as limited cases may have led to low scores, MCHIP is continuing to work with communities to increase demand for services. See Annex 3 for data on the 3 districts.

***Clinical Mentoring and Training.***
During this quarter, MCHIP continued providing on-the-job mentoring at all puskesmas and hospitals. Basic supplies and equipment were provided for infection prevention, and minor renovations were completed at the puskesmas.
Following these MCHIP inputs, almost all district has completed the third cycles. In midwives level in Serang, most of result increased in each tools.

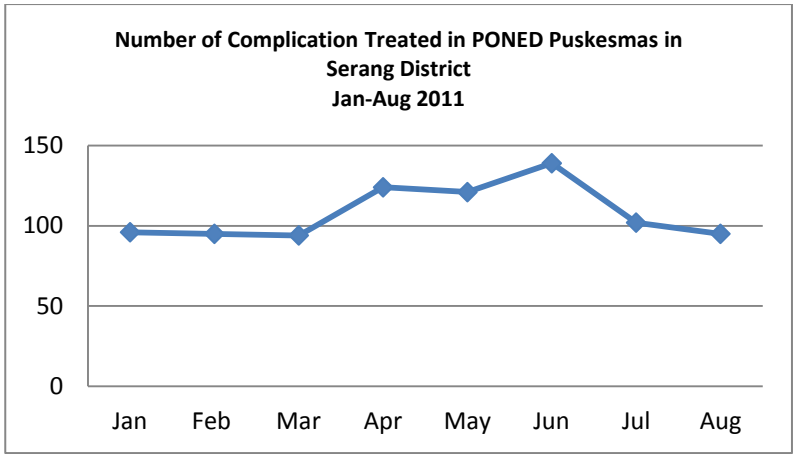
**SBMR Result at Midwifes Level in Serang Districts**
**(Bidan Ani Malisi, Desa Kebon at Tirataya Puskesmas)**
**Nov 2010 - July 2011**




| | Tool 1 Asuhan Ibu Hamil Terfokus | Tool 2 Persalinan Normal & Asuhan Segera BBLR | Tool 3 Asuhan Postpartum Ibu & Bayi | Tool 4 Komplikasi Saat Persalinan | Tool 5 Asuhan Keluarga Berencana | Tool 6 Asuhan KB Ulang - Pil & Suntik | Tool 7 Imunisasi Anak | Tool 8 Asuhan Balita | Tool 9 Tindakan Pencegahan Infeksi | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|
| 1st cycle | 30.0% | 20.0% | 31.3% | 16.7% | 25.0% | 14.3% | 60.0% | 25.0% | 6.7% | 22.9% |
| 2nd cycle | 90.0% | 70.0% | 75.0% | 58.3% | 60.0% | 71.4% | 100.0% | 50.0% | 33.3% | 65.1% |
| 3rd cycle | 100.0% | 100.0% | 100.0% | 83.3% | 80.0% | 85.7% | 100.0% | 75.0% | 93.3% | 91.7% |

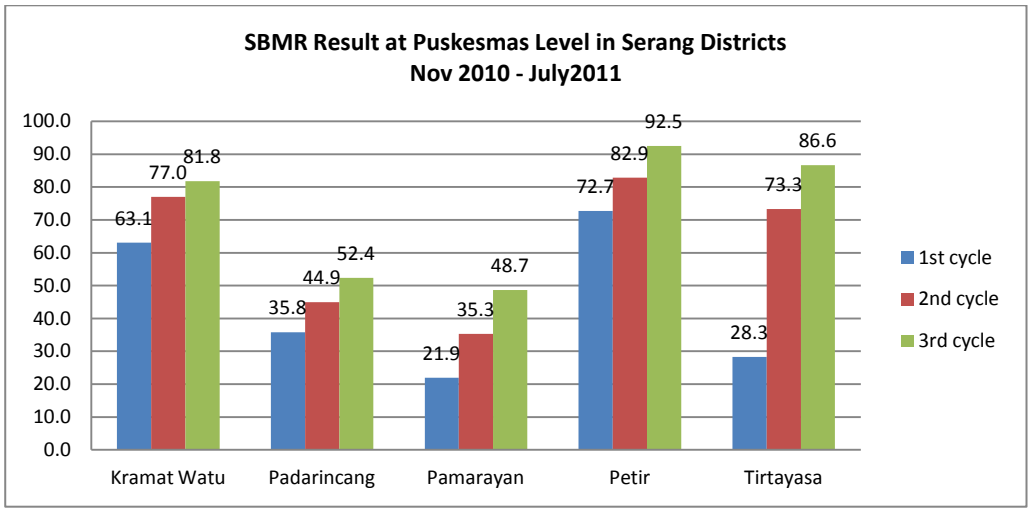
Strengthening in obstetric and neonatal referral for three districts was conducted in Budi Kemuliaan Hospital, Jakart. Total 12 participants includes senior midwives, ObGyn and pediatrician from Bireuen and Serang was trained. Unfortunately ObGyn and peditrician could not attend the training. This situation will be follow up in next quarter.

Resulting from MCHIP input on increasing the provider competency, Puskesmas in each district reported managed basic obstetric complications instead of referring women to the hospital. Below graph show the complication treated at Puskesmas level in Serang districts in 2011.

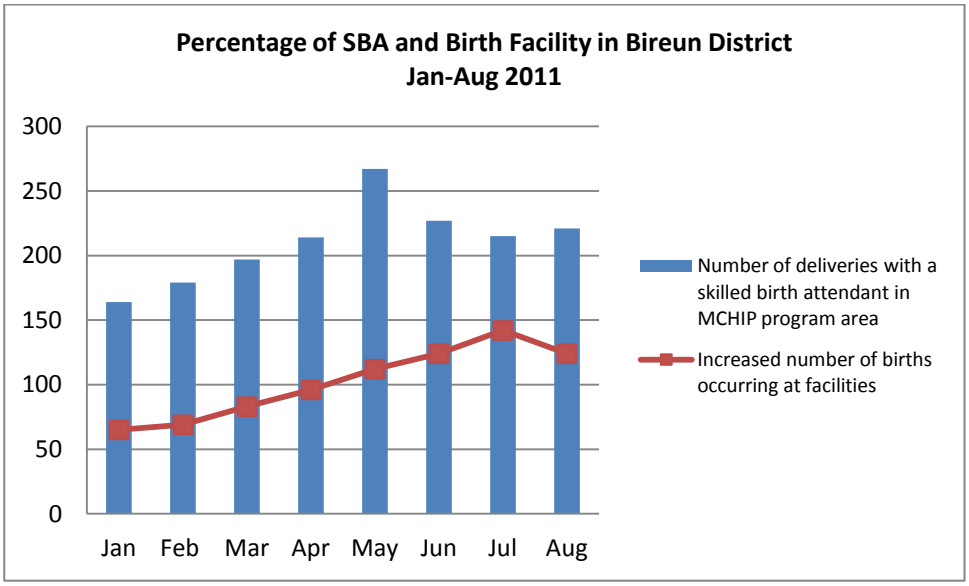



***Improved systems for quality assurance.*** Standards-Based Management and Recognition (SBM-R) is a practical approach to improving the quality of health care and the performance of service delivery systems. With technical assistance from Jhpiego, the approach has been implemented in over 20 programs in developing countries and across several health areas, including maternal child health, reproductive health, HIV/AIDS, and malaria Under MCHIP program, SBM-R has been implemented in three districts in the three Indonesia; Bireuen, Serang and Kutai Timur.

Facilities and midwives in all three districts continued to monitor and recognize their progress using the SBMR performance standards.
Puskesmas in Serang has increased the total performance standards, which most of the result in last quarter achieve less than 70% while the result in Quarter 4 has been increased to about 90%.




During this quarter, MCHIP continue assist Puskesmas and hospital for minor renovation and equipment design. Infection prevention and MCH room become one of the area that is targeted for renovation. As a result of MCHIP inputs on increasing the facility, puskesmas in each district reported managing births at facility as well as the increasing the skilled birth attendant. The graph below shows number of skilled birth attendant and births occuring at facility in Bireuen district.




**Sub-objective 4: Improve Management of the District Health System**

***Advocacy for budget allocations.*** Following the DTPS planning process in each district, MCHIP supported the DTPS advocacy teams to undertake advocacy activities. The Advocacy Teams include 3-4 members of the DTPS teams. MCHIP continuing assists the district to advocate the activity proposal to ensure the allocation in 2012 budget.

***Improved process for conducting maternal-perinatal audits.*** Effective maternal and perinatal audits are associated with improved quality of care and reduction of severe adverse outcomes[1]. Maternal Perinatal Audit (MPA) is for tracking the causes of maternal and perinatal morbidity and mortality to prevent future cases. MPA helps health personnel determine the conditions that resulted in the mortality/morbidity. The MPA can also function as a tool for monitoring and evaluation of the referral system. It is national policy of Indonesia to conduct a verbal autopsy of every maternal and perinatal death. The MPAs are done through a collaborative team from the DHO and the district hospital. Additionally the MOH has recently developed a revised process for conducting MPA and all districts are expected to implement this process. However, in many districts, the process is only partially implemented, if at all. MCHIP is providing inputs to establish routine maternal and perinatal audits in the three districts. All three districts participated in workshops to improve district processes for conducting maternal-perinatal audits (AMP). Although each district had previously been exposed to the AMP, the audits have been done sporadically, and the results have not been used systematically to address the gaps or problems that may have contributed to the deaths. For deaths that occur in the community, verbal autopsies are done at the health center or *puskesmas* by sub-district and district levels health officials. For deaths that occur at the hospital, district level health officials complete the verbal autopsy using hospital records.

[1] Pattinson RC, Say L, Makin JD, Bastos MH: **Critical incident audit and feedback to improve perinatal and maternal mortality and morbidity.** *Cochrane Database Syst Rev* 2005, (4):CD002961.

In this quarter, all districts participated in workshops to improve district processes for conducting maternal-perinatal audits (AMP). Although each district had previously been exposed to the AMP, the audits have been done sporadically, and the results have not been used systematically to address the gaps or problems that may have contributed to the deaths. The implementation of verbal autopsy has reached 100% in Bireuen, 43% in Kutai Timur and 67% in Serang.

***Data management***. During the DTPS process, it became clear to all involved that data management is weak in all three districts. Data is often insufficient, incomplete, or irrelevant. In order to strengthen data collection, reporting, and management, MCHIP M&E staff and provincial/district trainers conducted training and follow up in PWS/LAMAT in 3 districts. Participants in the training included the head of the puskesmas, midwife coordinator, data operator, MCH manager, village midwives, and DHO representatives. MCHIP continue assits Puskesmas by strengthening the monthly meeting (mini lokakarya) at Puskesmas level to work with village midwives and coordinator midwives to ensure data quality in MCH recording and reporting.

***Institutionalized commitment for MNCH.*** In order to institutionalize commitment for MNCH in Bireuen, several Local Law on MNCH drafted and finalized: Qanun KIBBLA, local law by head of district, POMA regulation (Obstetric Maternal and Perinatal Program). While in Kutai Timur, series of meeting conducted to develop MCH Local law, this includes hearing to deputy of DPRD. To continue support from local government and multistakeholders, Serang continuing the regular MNCH team monthly meeting at district and subdistrict level.

## Annex 1
## Progress Toward MCHIP Indicator

| Indicator | Bireuen | | | Kutai Timur | | | Serang | | |
|---|---|---|---|---|---|---|---|---|---|
| | **LOP Target** | **Achievement** | *Notes* | **LOP Target** | **Achievement** | *Notes* | **LOP Target** | **Achievement** | *Notes* |
| Number of district in MCHIP Province scaling up interventions | | | | | | | | | |
| Number of sub districts in MCHIP district scaling up interventions | **2** | **6** | | **2** | **6** | | **2** | **5** | |
| Percentage increase in number of births occurring at facilities | **10%** | **20%** | 180 births in Jun-Dec 2010 and 217 births in Jan-Aug 2011 in 6 target Puskesmas | **10%** | **10%** | 272 births in Jun-Dec 2010 and 301 births in Jan-Aug 2011 in 6 target Puskesmas | **10%** | **45%** | 186 births in Jun-Dec 2010 and 270 births in Jan-Aug 2011 in 5 target Puskesmas |
| Percentage of village midwives in MCHIP supported areas are competent in AMTSL | **100%** | **40%** | Baseline data from AMTSL survey | **100%** | **5%** | Baseline data from AMTSL survey | **100%** | **52%** | Baseline data from AMTSL survey |
| percentage of women with vaginal births who received Active management of the third stage of labor (AMTSL) at USG-supported facilities | **100%** | **67%** | 1,134 out of 1,684 births in 6 target Puskesmas | **100%** | **100%** | 640 out of 640 births in 6 target Puskesmas | **100%** | **94%** | 3,251 out of 3,457 births in 5 target Puskesmas |
| Percentage of MCHIP health facility using MgSO4 | **100%** | **14%** | 1 out of 6 target facilities (District Hospital Dr. Fauziah) | **100%** | **43%** | Puskesmas Kaliorang, Rantau Pulung and Kaubun | **100%** | **67%** | Puskesmas: Kramat Watu, Padarincang, Pamarayan, Tirtayasa |
| Number of MCHIP puskesmas PONED treating complications | **6** | **3** | Puskesmas: Jeumpa, Gandapura, Peudada | **6** | **6** | Puskesmas: Sangkulirang, Kaubun, Kaliorang, Sepaso, Rantau Pulung, Teluk Pandan | **5** | **5** | Puskesmas: Kramat Watu, Padarincang, Pamarayan, Tirtayasa, Petir |
| Percentage of maternal or neonatal deaths with autopsy verbal conducted | **100%** | **100%** | 15 deaths with 15 autopsy verbal in 3 Puskesmas (Jeumpa, Peudada, Juli, Makmur, Peusangan Selatan) | **100%** | **78%** | 27 deaths with 21 autopsy verbal in 5 Puskesmas (Bengalon, Teluk Pandan, Sangkulirang, Kaliorang, Kaubun) | **100%** | **47%** | 60 deaths with 28 autpsy verbal in 5 Puskesmas ( Kramat Watu, Padarincang, Pamarayan, Tirtayasa) |

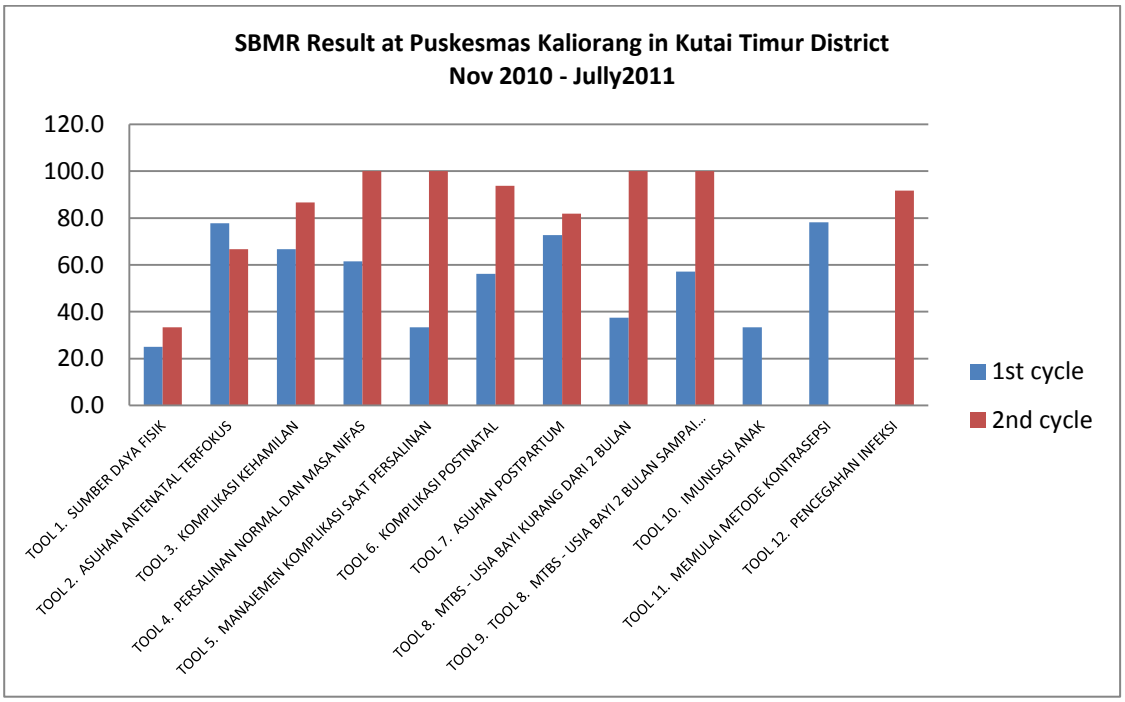
**Annex 2**
**Training Database as Per September 2011**

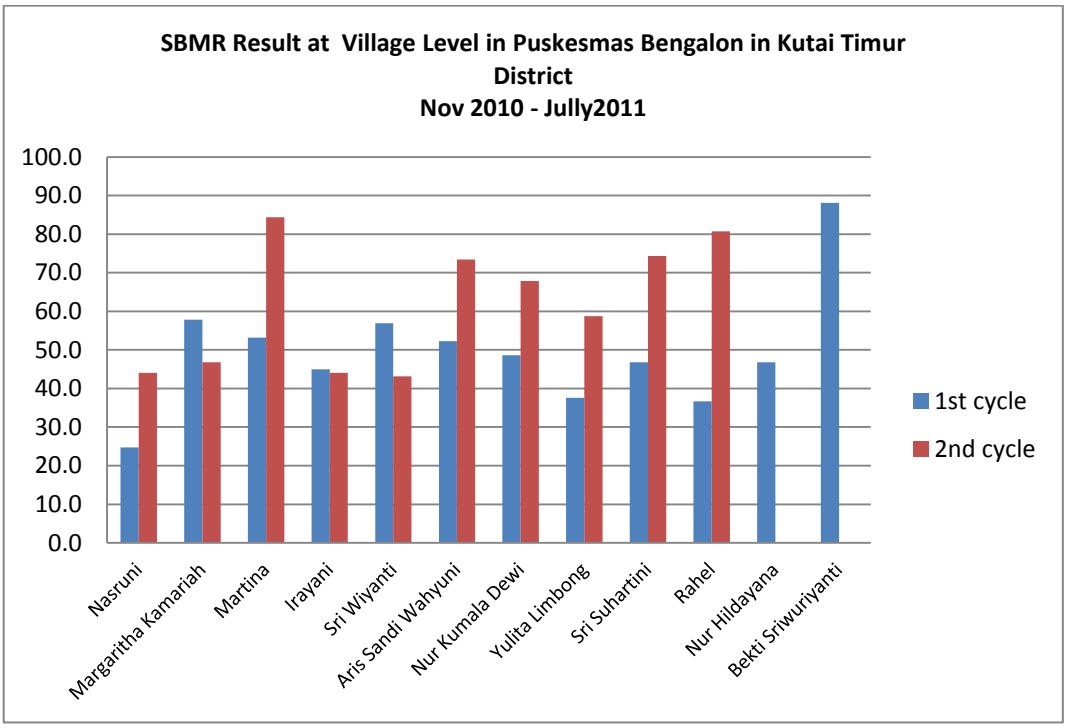
| No | Training | Bireuen | | | Kutai Timur | | | Serang | | | All Districts | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | M | F | Total | M | F | Total | M | F | Total | M | F |
| **SO 2: Improved Maternal and Newborn Care Services and Practices at the Community Level** | | | | | | | | | | | | | |
| 2.1 | Kader Training for MSG | 44 | 0 | 44 | 23 | 7 | 16 | 0 | 0 | 0 | 67 | 7 | 60 |
| 2.2 | Kader Training for CHC/Desa Siaga | 0 | 0 | 0 | 48 | 25 | 23 | 201 | 5 | 196 | 249 | 30 | 219 |
| 2.3 | KMC Socialization for Cadre | 29 | 0 | 29 | 0 | 0 | 0 | 0 | 0 | 0 | 29 | 0 | 29 |
| 2.4 | TOT CCM Facilitator | 15 | 0 | 15 | 18 | 2 | 16 | 0 | 0 | 0 | 33 | 2 | 31 |
| 2.5 | MSG Facilitator Training District Level | 7 | 0 | 7 | 6 | 2 | 4 | 0 | 0 | 0 | 13 | 2 | 11 |
| 2.6 | MSG Facilitator Training Puskesmas Level | 14 | 1 | 13 | 17 | 5 | 12 | 0 | 0 | 0 | 31 | 6 | 25 |
| 2.7 | MSG Facilitator Training Village Level | 146 | 0 | 146 | 140 | 12 | 128 | 15 | 2 | 13 | 301 | 14 | 146 |
| 2.8 | CCM Training for Health Worker | 69 | 0 | 69 | 34 | 6 | 28 | 0 | 0 | 0 | 103 | 6 | 97 |
| 2.9 | CCM Training for Kader | 0 | 0 | 0 | 18 | 3 | 15 | 0 | 0 | 0 | 18 | 3 | 15 |
| 2.10 | CCM Supervisor Training | 23 | 5 | 18 | 15 | 3 | 12 | 0 | 0 | 0 | 38 | 8 | 30 |
| 2.11 | Cadre Training of Desa Siaga Funding | 0 | 0 | 0 | 134 | 49 | 85 | 0 | 0 | 0 | 134 | 49 | 85 |
| 2.12 | Kader Training for Ambulance Desa Siaga | 0 | 0 | 0 | 121 | 78 | 43 | 0 | 0 | 0 | 121 | 78 | 43 |
| | **TOTAL** | **347** | **6** | **341** | **574** | **192** | **382** | **216** | **7** | **209** | **1137** | **205** | **791** |
| | | | | | | | | | | | | | |
| **SO 3: Improved Quality of Clinical Services at all Levels of Care** | | | | | | | | | | | | | |
| 3.1 | Refreshing Training Midwives | 66 | 0 | 66 | 0 | 0 | 0 | 0 | 0 | 0 | 66 | 0 | 66 |
| 3.2 | APN Training | 36 | 0 | 36 | 1 | 0 | 1 | 0 | 0 | 0 | 37 | 0 | 37 |
| 3.3 | IP Training | 145 | 26 | 119 | 112 | 33 | 79 | 91 | 22 | 69 | 348 | 81 | 267 |
| 3.4 | KMC Training | 33 | 5 | 28 | 26 | 3 | 23 | 34 | 2 | 32 | 93 | 10 | 83 |
| 3.5 | Lactation Management Training | 30 | 2 | 28 | 24 | 1 | 23 | 30 | 3 | 27 | 84 | 6 | 78 |
| 3.6 | Learning Organization Training | 24 | 3 | 21 | 15 | 4 | 11 | 22 | 3 | 19 | 61 | 10 | 51 |
| 3.7 | PONED Training | 0 | 0 | 0 | 7 | 1 | 6 | 4 | 0 | 4 | 11 | 1 | 10 |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.8 | Training Evaluator for the Effect of Intervention Quality on MNCH Service | 9 | 1 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 1 | 8 |
| 3.9 | OJM for health provider | 0 | 0 | 0 | 0 | 0 | 0 | 131 | 1 | 130 | 131 | 1 | 130 |
| 3.10 | MNERC Training | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 3 | 7 | 10 | 3 | 7 |
| | **TOTAL** | **343** | **37** | **306** | **185** | **42** | **143** | **322** | **34** | **288** | **850** | **113** | **737** |
| | | | | | | | | | | | | | |
| **SO 4: Improved Management of the District Health System** | | | | | | | | | | | | | |
| 4.1 | TOT Pramusrenbangdes | 28 | 10 | 18 | 18 | 10 | 8 | 24 | 14 | 10 | 70 | 34 | 36 |
| 4.2 | TOT DTPS | 36 | 5 | 31 | 0 | 0 | 0 | 0 | 0 | 0 | 36 | 5 | 31 |
| 4.3 | PTP Workshop | 64 | 23 | 41 | 51 | 27 | 24 | 60 | 20 | 40 | 175 | 70 | 105 |
| 4.4 | DTPS Workshop | 25 | 12 | 13 | 12 | 6 | 6 | 26 | 10 | 16 | 63 | 28 | 35 |
| 4.5 | PWS-KIA Orientation | 0 | 0 | 0 | 178 | 40 | 138 | 0 | 0 | 0 | 178 | 40 | 138 |
| 4.6 | PWS-KIA Training | 0 | 0 | 0 | 56 | 1 | 55 | 0 | 0 | 0 | 56 | 1 | 55 |
| 4.7 | Advocacy Training DTPS-KIBBLA | 13 | 4 | 9 | 0 | 0 | 0 | 0 | 0 | 0 | 13 | 4 | 9 |
| | **TOTAL** | **166** | **54** | **112** | **315** | **84** | **231** | **110** | **44** | **66** | **591** | **182** | **409** |
| | | | | | | | | | | | | | |
| | **TOTAL** | **856** | **97** | **759** | **1,074** | **318** | **756** | **648** | **85** | **563** | **2,578** | **500** | **1,937** |

**Annex 3**

**SBMR results for Midwives, Puskesmas and Hospital Level**



**Annex 4**
**Finding KMC Monitoring and Evaluation in 3 Hospitals**

**Summary Finding in RSUD Serang, Serang District**

Berdasarkan hasil analisis situasi tersebut di atas, baik dari wawancara, *FGD*, maupun observasi, maka dapat disimpulkan:

*Strengths* (kekuatan):
1. Tenaga terlatih PMK sudah ada 7 orang (2 dokter dan 5 perawat).
2. Ada kesadaran dari staf pentingnya PMK dilaksanakan.
3. PMK sudah mulai dilaksanakan dan cukup didukung oleh pimpinan dan manajemen.
4. Ruangan memungkinkan untuk dilakukan PMK.
5. Ruang perawatan sedang direnovasi yang berarti memungkinkan terjadinya perubahan penataan
6. Beberapa media KIE tersedia, seperti cara menyusui, perawatan BBLR di rumah.
7. Formulir pengkajian keperawatan, formulir pemantauan bayi secara umum, catatan perkembangan sudah tersedia.

*Weaknesses* (kekurangan):
1. Sarana prasarana: kursi, timbangan, untuk pengendalian infeksi.
2. Persepsi tentang PMK belum sama.
3. Belum ada SPO/SOP.
4. Media KIE untuk PMK belum ada khususnya berupa *leaflet* agar bisa dibawa oleh ibu.
5. SDM kurang.
6. Keterampilan tenaga kesehatan kurang.
7. Staf yang dilatih belum semua melaksanakan RTL pasca pelatihan.
8. Belum ada mekanisme pemantauan bayi yang sudah pulang pasca PMK.
9. Sistem pendokumentasian PMK belum ada.

*Opportunity* (peluang)
1. Ada kebijakan nasional
2. Dukungan dari Pemda/Dinas Kesehatan
3. Sistem Jejaring

*Threat* (Ancaman):
1. Hanya ada kebijakan nasional, tetapi kurang didukung oleh upaya lain misalnya sosialisasi tentang PMK di media massa.
2. Kesadaran orang tua kurang.

Isu Strategis:
1. Belum ada kebijakan tertulis di RSUD (SK Direktur) terkait PMK.
2. SPO/SOP belum ada.
3. Media KIE belum ada.
4. Sistem pendokumentasian belum optimal.
5. Kurangnya sarana dan prasarana.
6. Staf terlatih perlu ditambah dan ditingkatkan keterampilannya.
7. Pemantauan bayi pasca keluar dari RS belum dilakukan.

REKOMENDASI

1. Perlu dibuat kebijakan direktur terkait PMK dalam bentuk SK .SOP PMK perlu dikembangkan sesuai dengan kondisi RSUD.
2. Perlu dikembangkan media cetak KIE terkait PMK.
3. Sistem pendokumentasian perlu diperbaiki dengan menggunakan format yang tersedia.
4. Sarana dan prasarana perlu dilengkapi: seperti timbangan, kursi, *screen* untuk memberi privasi pada ibu
5. Perlu pemantauan pelaksanaan PMK dari atasan langsung khususnya bagi staf yang sudah dilatih dan untuk yang belum agar diikutkan dalam pelatihan
6. Sistem jejaring perlu dikembangkan antara RS-Dinas Kesehatan dan Petugas Kesehatan di komunitas untuk memantau kesehatan bayi setelah pulang dari RS.

**Summary Findings in RSUD dr. Fauziah, Bireuen District**

**Kesan dan Masukan**

- Terapan PMK di rumah sakit sangat tergantung dari kesungguhan, ketekunan dan minat dokter spesialis anak selaku penanggung jawab UPF Anak. Kesungguhan dan minat tersebut perlu disambut dan ditindaklanjuti oleh perawat di ruang perinatologi. RSUD dr Fauziah Bireuen pernah mendapatkan kejuaraan lomba Rumah Sakit Sayang Ibu dan Bayi (RSSIB) di tahun 2004. Hal ini tentunya menjadi potensi dalam terapan PMK karena PMK adalah bagian dari kriteria lomba. Keinginan untuk mengikuti Lomba RSSIB di tahun-tahun mendatang tentunya menjadi potensi keberhasilan terapan PMK. Apalagi dalam kaitan ini staf rumah sakit masih mengingat adanya kebijakan untuk tidak memberikan susu formula sebagai konsekuensi dari penetapan sebagai RSSIB. Kebijakan tersebut tampaknya dipahami staf rumah sakit sebagaimana terungkap dalam wawancara dengan staf RS.
- Perlu pengembangan prosedur baku dalam pelaksanaan PMK untuk BBLR dalam bentuk panduan tertulis yang dapat menjadi pegangan bagi semua personel yang bertugas di ruang perinatologi. Dalam hal ini Perinasia dapat membantu penyusunan panduan dengan melibatkan dokter spesialis anak.
- Perlu pengembangan sistem pencatatan dan pelaporan secara baku yang dipahami oleh semua petugas di ruang perinatologi.
- Perlu penataan ulang ruang perinatologi dan kelengkapan alat/sarana agar dapat memenuhi persyaratan ruang perawatan. Termasuk dalam hal ini adalah penyediaan sarana untuk memandikan bayi, mencuci tangan, timbangan digital, kulkas penyimpan ASI perah.
- Ruang yang dirancang untuk PMK perlu dilengkapi dengan pendingin ruangan (AC). Dua *exhaust fans* yang tersedia sekarang dapat dikatakan tidak mencukupi kebutuhan ventilasi ruangan yang cukup, apalagi ruangan tidak berjendela.
- Dilakukan sosialisasi lebih luas antara lain dengan pengembangan materi KIE seperti spanduk (*banner*) yang ditempatkan di lokasi selain unit perinatologi. Istilah setempat untuk kanguru yaitu *Peu Uem Aneuk Ba Dada Poma* (peluk anak di dada ibu) memang memudahkan pengertian namun perlu dipertimbangkan bahwa PMK tidak hanya dilakukan ibu. *Peu Uem Aneuk Ba Dada* (peluk anak di dada) barangkali lebih tepat.
- Mengingat RSUD Bireuen juga melayani masyarakat di luar Kabupaten Bireuen maka kemampuan dan sarana yang ada perlu ditingkatkan. Kerjasama antara rumah sakit dan pemerintah daerah, terutama dengan Dinas Kesehatan diharapkan dapat ditingkatkan agar pengembangan jejaring sampai ke tingkat masyarakat dapat terwujud. Kerjasama meliputi pengembangan program pelatihan, orientasi, sosialisasi ke semua pihak terkait dalam pelayanan PMK, baik secara medis maupun non-medis.

- Menilik jumlah BBLR yang tercatat dalam 6 bulan sebesar 11,5 % perlu dipertimbangkan untuk melakukan penelitian guna mengungkap penyebab BBLR. Berdasarkan pengamatan sementara menurut wawancara petugas kesehatan di ruang perinatologi dengan ibu diduga BBLR terkait dengan nutrisi ibu (kurang gizi) dan aktivitas ibu (terlalu banyak berdiri). Penelitian akan mengungkapkan penyebabnya secara pasti sehingga intervensi dalam rangka pencegahannya bisa dilakukan secara lebih efisien dan efektif. Usulan ini mendapat perhatian dari Direktur RSUD dr Fauziah Bireuen dan Kepala Dinas Kesehatan.
- Perlu dipertimbangkan pula pengembangan jejaring ke tingkat rujukan tertinggi di daerah yaitu RSU dr Zainoel Abidin di Banda Aceh.
- Peningkatan keterampilan petugas dan pengembangan sistem yang terkait dengan terapan PMK di rumah sakit dapat dilakukan dengan mengirim petugas kesehatan ke RS yang sudah menerapkan PMK, baik di tingkat daerah (RSU dr Zainoel Abidin di Banda Aceh) maupun pusat (RSUPNCM), juga RS Budi Kemuliaan dan RSUD Cianjur.
- Dalam kaitan dengan visi rumah sakit yang ingin menjadikan RSUD dr Fauziah Bireuen sebagai pusat rujukan regional wilayah utara yang berkualitas, dengan pelayanan prima di tahun 2012 tentunya memerlukan dukungan kemampuan manajemen secara menyeluruh. Dalam kaitan ini terapan PMK perlu disesuaikan dengan rencana kerja rumah sakit dalam operasional penjabaran visi dan misinya. Di antaranya adalah mengembangkan program supaya dapat menjadi rujukan bagi pelayanan PMK dari rumah sakit kabupaten yang berdekatan dan belum menerapkan PMK secara formal.

**Summary Findings in RSUD Sangatta, Kutai Timur District**

**Kesimpulan**

- Ada komitmen direktur yang dapat menjadi dasar pengembangan Program PMK di RSUD Sangatta.
- Diperlukan pendampingan untuk dapat menjabarkan komitmen tersebut dalam rancangan operasional yang melibatkan semua pihak agar terapan PMK mendapatkan dukungan sehingga terapannya bisa maksimal dan optimal (unsur manajemen dan terapan secara medis-teknis).
- Sosialisasi Terapan PMK di RSUD Sangatta perlu dilakukan secara terencana dan dalam perinci yang jelas agar tujuan penerapan PMK sebagai upaya penanganan BBLR dengan cara yang efisien dan efektif dapat tercapai.

**Annex 5**
**Findings AMTSL Survey for Village Midiwves in 3 Districts**

Bireuen District

| Kecamatan | Kompeten | % | Tdk Kompeten | % | Total |
|---|---|---|---|---|---|
| **Gandapura** | **25** | **45%** | **30** | **55%** | **55** |
| Bidan PKM | 11 | 65% | 6 | 35% | 17 |
| MCHIP | 2 | 22% | 7 | 78% | 9 |
| Non MCHIP | 12 | 41% | 17 | 59% | 29 |
| **Jeumpa** | **7** | **13%** | **45** | **85%** | **53** |
| Bidan PKM | 5 | 28% | 13 | 72% | 18 |
| MCHIP | 0 | 0% | 6 | 100% | 6 |
| Non MCHIP | 2 | 7% | 26 | 90% | 29 |
| **Juli** | **10** | **37%** | **17** | **63%** | **27** |
| Bidan PKM | 4 | 36% | 7 | 64% | 11 |
| MCHIP | 2 | 33% | 4 | 67% | 6 |
| Non MCHIP | 4 | 40% | 6 | 60% | 10 |
| **Makmur** | **20** | **59%** | **12** | **35%** | **34** |
| Bidan PKM | 3 | 43% | 4 | 57% | 7 |
| MCHIP | 8 | 80% | 2 | 20% | 10 |
| Non MCHIP | 9 | 53% | 6 | 35% | 17 |
| **Peudada** | **17** | **50%** | **17** | **50%** | **34** |
| Bidan PKM | 4 | 44% | 5 | 56% | 9 |
| MCHIP | 7 | 78% | 2 | 22% | 9 |
| Non MCHIP | 6 | 38% | 10 | 63% | 16 |
| **Peusangan Selatan** | **1** | **3%** | **31** | **97%** | **32** |
| Bidan PKM | 0 | 0% | 16 | 100% | 16 |
| MCHIP | 0 | 0% | 8 | 100% | 8 |
| Non MCHIP | 1 | 13% | 7 | 88% | 8 |
| **Grand Total** | **80** | **34%** | **152** | **65%** | **235** |
| Bidan PKM | 27 | 35% | 51 | 65% | 78 |
| MCHIP | 19 | 40% | 29 | 60% | 48 |
| Non MCHIP | 34 | 32% | 72 | 68% | 106 |

Kutai Timur District

| Puskesmas | Jumlah Bidan | Bidan Mengikuti Survey MAK 3 | Kompeten | | |
|---|---|---|---|---|---|
| | | | Jumlah | % | Nama |
| Sepaso | 14 | 12 | 0 | 0% | |
| Kaliorang | 15 | 10 | 1 | 10% | Ummu Hulafiah |
| Kaubun | 14 | 12 | 1 | 8% | Lilis |
| Sangkulirang | 10 | 9 | 0 | 0% | |
| Teluk Pandan | 12 | 10 | 1 | 10% | Rosalia |
| Rantau Pulung | 4 | 2 | 1 | 50% | Maya Karsanti |

Serang District

| Puskesmas | Total Bidan | Bidan yg di asses | Komp eten | % |
|---|---|---|---|---|
| Petir | 21 | 17 | 9 | 52,9 |
| Tirtayasa | 21 | 21 | 11 | 52,3 |
| Padarincang | 18 | 17 | 8 | 47,1 |
| Pamarayan | 15 | 15 | 6 | 40,0 |
| Kr. Watu | 25 | 24 | 7 | 29.2 |
| **TOTAL** | **100** | **94** | **49** | **52,1** |

Grafik hasil penilaian MAK3 di 5 puskesmas